

PATIENT REGISTRATION

PATIENT INFORMATION (please print clearly)

First name:			Middle name:			Last name:		
Date of birth:			Age:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Social Security No.:	
Parent/Guardian name (if patient under 18):								
Patient's address:				City:			State & zip code:	
Home telephone:			Mobile telephone:			Email address:		
Occupation:				Employer:				
Employer's address:				City:			State & zip code:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed								
Ethnicity*:			Race*:			Preferred language*:		
<input type="checkbox"/> **Decline to state						Translator needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
* Federal insurance programs and other insurances that receive federal funding require that we obtain this information. **If you do not wish to furnish this information.								
How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Friend/Family <input type="checkbox"/> Google <input type="checkbox"/> Insurance <input type="checkbox"/> Employer <input type="checkbox"/> ZocDoc								
<input type="checkbox"/> Hospital/ER <input type="checkbox"/> Other:								

HEALTH INSURANCE INFORMATION

Primary Insurance Company Name:

Address:			City:			State & zip code:		
Policy/ID #:			Group #:			Name of Policyholder:		
Relationship to patient:			Date of birth:			Is this an HMO/PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Secondary Insurance Company Name:

Address:			City:			State & zip code:		
Policy/ID #:			Group #:			Name of Policyholder:		
Relationship to patient:			Date of birth:			Is this an HMO/PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No		

PERSON FINANCIALLY RESPONSIBLE/INSURED (Complete only if patient is not the main policy holder)

First name:			Middle name:			Last name:		
Relationship to patient:			Date of birth:			Social Security No.:		
Home address:				City:			State & zip code:	
Home telephone:			Mobile telephone:			Email address:		

Name: _____ Age: _____ Gender: M F Appointment date: _____

AUTOMOBILE ACCIDENT

Date of accident: _____ Time: _____ am pm Were you: Driver Passenger

Do you have medical benefits under your auto ins.? Yes No If **YES**, Policy No./Claim#: _____

Your Automobile Insurance Carrier:

Address: _____ City: _____ State & zip code: _____

Telephone no.: _____

Your Agent's Name: _____ Telephone no.: _____

Your claim adjuster's name: _____ Telephone no.: _____

Other Party's Automobile Carrier:

Address: _____ City: _____ State & zip code: _____

Telephone no.: _____

Other Party's Claim Adjuster's Name:

Claim No.: _____ Telephone no.: _____

COMPLETE IF AN ATTORNEY IS REPRESENTING YOU

Attorney's name: _____ Telephone no.: _____ Fax no.: _____

Address: _____

WORKERS' COMPENSATION (Injury on the Job)

Date of injury: _____ Time: _____ am pm Claim no.: _____

Compensation Insurance Co.: _____ Address: _____

Insurance company: _____ Contact person: _____ Telephone no.: _____

Employer at time of injury: _____ Telephone no.: _____ Was injury reported to supervisor? Yes No

Date reported: _____ Name of supervisor: _____ Telephone no.: _____

Patient/Guardian signature _____ Date: _____

For staff use only

TYSONS CORNER FALLS CHURCH HERNDON OFFICE

Patient Chart Number: _____



PERSONAL DETAILS

Name: _____ Age: _____ Gender: M F Appointment date: _____

Emergency Information: who should we notify in case of emergency?

	Name	Relationship	Home Phone	Mobile Phone
Nearest relative/friend Living with you:				
Nearest relative/friend NOT living with you:				

Authorization

I, _____ hereby authorize CENTER FOR ORTHOPAEDICS AND SPORTS MEDICINE, INC. to apply for benefits on my behalf for covered services rendered by CENTER FOR ORTHOPAEDICS AND SPORTS MEDICINE, INC. I REQUEST THAT PAYMENT FOR THESE SERVICES BE PAID BY _____

Insurance Company #1 *S.S. # of Insured/ID* *Group*

Insurance Company #2 *S.S. # of Insured/ID* *Group*

Directly to Center for Orthopaedics and Sports Medicine, Inc. This is a direct assignment of my rights and benefits under the above-mentioned policy/policies. I certify that the information I have provided above is correct. I further authorize Center for Orthopaedics and Sports Medicine, Inc. to release any necessary information, including medical information, for this or any related claim to the insurance companies named above, or in the case of medicare part b benefits, to the social security administration and health care financing administration. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that I am responsible for the full settlement of my account regardless of insurance payments or reimbursements.

Witness signature *Patient/Guardian signature* *Date*

Financial Policies

For the benefit of our patients, our billing policies are described below.

1. Payment of the charges for our services is the ultimate responsibility of the patient. Payment is expected at the time services are rendered, except when alternative arrangements are made in advance with us.
2. Patients being scheduled for elective (planned) surgical procedures may be required to post a deposit amount before surgery which usually reflects the estimated part of the patient's responsibility for the procedure being planned. Any adjustments will be made following the patient's insurance company's payment of the procedure.

PLEASE NOTE: Patients being scheduled for physical therapy may require electrical stimulation. As a part of treatment, the use of electrodes may be necessary. These electrodes have contact with the patient's skin and for the patient's safety; patients will be required to purchase his/her own electrodes. The cost to the patient for these electrodes is a ONE-TIME fee of \$17.50/pair. Should this treatment be deemed necessary, you agree to be responsible for this fee at the time of service.

Please be aware that insurance companies often do not fully cover a medical bill. This may result from deductible or co-payment provisions in the patient's policy, or because the insurance company has adopted a fee schedule, or for other reasons. However, an insurance company's failure to fully cover our bill does not relieve the patient of the obligation to pay our bill in full.

There will be a \$35.00 Fee assessed to the patient for any physician appointment which is not cancelled 24 hours prior to the appointment time. Missed appointment fee is not covered by any insurance. It will be due from the patient.

If our bill is not paid in full when due, we encourage you to discuss with our billing staff alternative payment arrangements that may be acceptable to us. Generally, however, any bill not paid within 90 days will be referred for collection. Following 90 days delinquency, monthly interest charge of 1.4% Will accrue on the balance and all collection charges including attorney's fees of 20% on the unpaid balance and court costs will be added to the patient's account.

Initial Please indicate that you have read and understood the foregoing billing policies by signing below.

Patient's/Responsible party's signature *Patient's printed name* *Date*

Witness signature *Witness's printed name* *Date*



COVID-19 PANDEMIC TREATMENT CONSENT FORM

Name: _____ Age: _____ Gender: M F Appointment date: _____

**** We are requesting all patients wear a mask at the time of their visit ****

We have numerous guidelines in place to minimize the risk of transmission. Nonetheless, it is still possible to contract COVID-19 while at a medical office.

1. I knowingly and willingly consent to have treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious.
2. I understand that due to the frequency of visits of other patients, the characteristics of the COVID-19 virus, and the characteristics of medical procedures, I have an elevated risk of contracting the COVID-19 virus simply by being in a medical office.
3. I confirm that I am not presenting any of these COVID-19 symptoms – fever, shortness of breath, dry cough, runny nose, sore throat.
4. I confirm that I have not been in contact with a person who has been diagnosed with COVID-19 within the past 14 days.
5. I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus, and that the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with medical treatment.
6. I verify that I have not traveled outside the United States in the past 14 days.
7. I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the office of any changes in medical status.

Relationship to patient: Self Parent

Patient/Guardian signature _____

Date: _____



PATIENT HEALTH HISTORY

Name:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Appointment date:
Height:	Weight:	Temp:	
Name of primary care (family) physician:		Consult requested by:	
Preferred pharmacy (name and address):			

CURRENT MEDICATIONS

Are you currently taking any blood thinners? Yes No

What medications are you currently taking?

Name:	Dosage:	Frequency:
Name:	Dosage:	Frequency:
Name:	Dosage:	Frequency:

* If you have additional medications, please list on a separate sheet.

PAST HEALTH HISTORY

Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	Major infection <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Elevated cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS / HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CPAP
Blood clots/DVT <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: <input type="checkbox"/> High <input type="checkbox"/> Low
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: <input type="checkbox"/> I <input type="checkbox"/> II	Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	If YES, list: _____

FAMILY HISTORY

Father – Alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age deceased: _____	Health Status: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Mother – Alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age deceased: _____	Health Status: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Heart Disease <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Hypertension <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Asthma <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
COPD <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Arthritis <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Osteoporosis <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Stroke <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Diabetes before age 18 <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Diabetes after age 18 <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		
Bleeding problems <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister		



SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)? Yes No If **YES**, please list what type of problems:

Have you ever had surgery before? Yes No If **YES**, please list all surgeries:

SOCIAL HISTORY

Do you currently smoke? Yes No # packs/day

Have you ever smoked? Yes No # of years # packs/day

Alcohol use: None Socially Rarely Moderately Heavily

Drug use: None Type/Frequency:

Exposure at home or work to: None Smoke Fumes Other:

Do you exercise? Yes No How often # times/week:

Type of exercise:

ALLERGIES

Are you allergic to any of the following: Adhesive tape Antibiotics Latex Barbiturates (Sleeping pills) Aspirin
 Iodine Codeine Sulfa Local anaesthetics

Do you have any other allergies? Name: Reaction:

No known drug allergies (NKDA) Name: Reaction:

REVIEW OF SYSTEMS

Problems you have or have had recently in the following areas (check all symptoms that apply):

General/Constitutional None Weight gain Weight loss Fever and chills Fever

Eyes None Eye pain Red eyes

ENT None Dizziness Hearing loss Ear pain Nosebleeds Sore throat

Heart and Blood vessels None Chest pain Irregular heart beat Swelling

Lungs and Respiratory system None Non-productive cough Productive cough Coughing up blood

Stomach and Digestive system None Abdominal pain Frequent nausea Frequent vomiting

Bones, Joints or Muscles None Cramping Pain in back Painful joints Stiffness Weakness

Neurologic None Frequent headache Face pain Seizures Loss of consciousness
 Tingling Fatigue

Mental and Emotional health None Trouble sleeping Anxiety Depression

Endocrine None Increased appetite Increased fatigue Increased thirst
 Enlarged neck Pain in neck

Allergies, Infections, Immune system None Frequent infections Severe reaction to insect bite

Patient/Guardian signature

Date:



MEDICAL HISTORY FORM: GENERAL

Name: _____ Age: _____ Gender: M F Appointment date: _____

REASON FOR VISIT

What is the reason for your visit today? (Please include all relevant details)

Location: Right Left Bilateral (Both Left & Right)

Which is your dominant hand? Right Left Neither (Ambidextrous)

Do you use any of the following assistive device to walk? (Check all that apply) No assistive device Cane Crutches Walker Wheelchair

Context: Is this the result of an injury? If so, what date did it occur? Yes No

If **YES**, what type of injury? Sports injury: What sport? Car accident (MVA) Other:

Work related: Did this injury occur while working? If so, what date did it occur? Yes No

Duration: How long have you had this problem?

Onset: How quickly did the pain start? Suddenly (Immediate onset, as in on injury) Gradual (slowly, overtime)

Status: How has the pain changed? Improving Resolved Stable Worse

Frequency: How often is the pain present? Intermittent (comes and goes) Constant Rare

Intensity: On a scale of 1-10 (10 being the most painful), how severe is the pain? 1 2 3 4 5 6 7 8 9 10

Quality: How would you describe the pain? Aching Burning Dull Sharp Throbbing

Aggravated by (what makes the pain worse?) Nothing Lifting Reaching Overhead motions Sitting Stairs Walking Activity Work Other:

Relieved by (what makes the pain better?) Nothing Brace/splint Elevation Exercise Ice Injections Massage Physical Therapy Stretching Rest Other:

Do you have any of the following associated symptoms?

Decreased mobility (stiffness) Yes No Numbness Yes No

Instability (giving away) Yes No Popping (something clicking) Yes No

Locking (stick in position) Yes No Swelling Yes No

Night pain Yes No Weakness Yes No

Have you used any medication for this problem?

Anti-inflammatory medications - Please list (e.g. Ibuprofen, Advil, Aleve):

Pain (prescription) medications - Please list:

Does the medication relieve your pain? Yes No Temporarily/Partially

Imaging: Have you had any of the following? X-rays MRI CAT scan Doppler U/S EMG/NCV Bone Density Other:



Additional History

Please list any other details about your pain or injury that have not been covered above

Have you had any previous surgery for this condition?

Yes No

If **YES**, please list the date(s) and type of evaluations and/or treatments.

Unsuccessful treatments:

What previous treatments have you tried that have been unsuccessful?

Nothing Brace/splint Exercise Heat
 Ice Massage Rest Physical Therapy

History: In the past have you ever had another problem to this same part of your body?

Yes No

If **YES**, please list the date(s), type of evaluations and/or treatments and whether or not your symptoms were resolved.
